

Washington State Health Care Authority

Report to the Legislature

Accountable Care Organization Pilot Projects

Engrossed Substitute Senate Bill 6522

Chapter 220, Laws of 2010

January 1, 2013

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Executive Summary

Engrossed Substitute Senate Bill 6522, enacted as Chapter 220, Laws of 2010 RCW 70.54.420 (the Act) directs the Health Care Authority (HCA) to appoint a lead organization to establish and oversee two Accountable Care Organization (ACO) pilot projects—one with an integrated provider panel and one on a community network model. Section 2 (6) directs the lead organization for the pilot projects established pursuant to the Act to provide a report to the health care committees of the legislature, by January 1, 2013, on the progress of the accountable care organization pilot projects, recommendations about further expansion and needed changes to the statute to more broadly implement and oversee accountable care organizations in the state.

In the absence of such a lead organization, this report is submitted by the Health Care Authority to document its efforts to appoint a lead organization and initiate the pilot projects, as well as subsequent activity that potentially may yield some of the anticipated benefits of the Act.

Following enactment, the then-Assistant Director for Health Care Policy, Richard Onizuka, PhD, issued a request for information (RFI) from prospective lead organizations. Discussion with the most promising candidate continued through the summer and autumn of 2010, and a draft memorandum of agreement (MOU) was issued in December. Discussions continued into January 2011 when it was determined that agreement could not be reached. Dr. Onizuka reached out to a succession of other potential candidates, but none chose to pursue the opportunity. Following discussion with then-Senator Cheryl Pflug, sponsor of the Act, it appeared that rather than continue pursuing the model embodied in the Act, it could be possible to incorporate some of its principles into Senate Bill 5394 of 2011, which was under legislative consideration at the time.

Engrossed Substitute Senate Bill 5394 was subsequently enacted, directing that the insured and self-funded health plans serving Public Employee Benefit (PEB) beneficiaries establish incentive payment for health care providers that incent reduction in preventable emergency department (ED) and ambulatory-sensitive acute inpatient utilization. The same requirement was established for health plans contracted to serve the Medicaid Healthy Options and Basic Health populations. Active pursuit of a lead organization under ESSB 6522 was discontinued.

Since then, HCA has submitted to the Centers for Medicare and Medicaid Innovation (CMMI) a proposal for the State Innovation Models initiative that targets some major objectives of the Act. If funded, this initiative will provide an opportunity to evaluate the effectiveness of these new approaches to health care delivery and finance reform.

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Key Provisions of the Act

The Act directs the Administrator of the Health Care Authority (HCA) to appoint a lead organization to support two distinct accountable care organization (ACO) pilot projects; one utilizing integrated health care delivery systems and the other based on provider networks. The lead organization was to be appointed by January 1, 2011 and the two pilot projects in process of implementation by January 1, 2012.

The Act defines an ACO as an entity that enables networks consisting of health care providers or a health care delivery system to become accountable for the overall costs and quality of care for the population they jointly serve and to share in the savings created by improving quality and slowing spending growth while relying on the principles of local accountability, appropriate payment and delivery models, and performance measurement.

The Act specifies that the lead organization shall be representative of health care providers and payors across the state; have expertise and knowledge in medical payment and practice reform; be able to support the costs of its work without recourse to state funding (although it and HCA are encouraged to seek funding from other sources); identify and convene workgroups as needed, in collaboration with HCA to accomplish the goals of the Act; research other opportunities to establish ACO pilot projects; coordinate the ACO selection process with the HCA primary care medical home reimbursement pilot projects and the joint learning collaborative of the Department of Health and Washington Academy of Family Physicians; and submit regular reports to the administrator on the progress of implementing the requirements of the Act. It further specifies that in order to obtain expert guidance and consultation in design and implementation, the lead organization shall contract with a recognized national learning collaborative with a reputable research organization having expertise in the development and implementation of ACOs and payment systems.

The Search for a Lead Organization

The request for information (RFI) issued in June 2010 addressed these requirements and invited candidate organizations to respond to a series of questions relating to their preparedness to meet the requirements of the Act. Two responses were received, and of those the candidate which appeared better prepared was selected for negotiation of a memorandum of understanding (MOU).

In the course of these negotiations it became apparent that the candidate's and HCA's visions for the role of the lead organization diverged. The primary difference among several considerations was that the candidate was interested in establishing and operating the integrated delivery system pilot, but wished to delegate the lead organization role for the network-model pilot to another lead organization with no responsibility for the success of its development, implementation or operation. In HCA's view this approach failed to meet the public interest objective of having a single lead organization oversee, promote and report on both pilots. In January 2011, it was mutually agreed that HCA would seek another candidate for the lead organization role.

HCA initially approached the other original applicant, who declined the opportunity on the basis that it lacked resources to devote to it and had concerns about the readiness of the state's providers to participate in multipayer ACO initiatives as opposed to the more familiar medical home and learning collaborative models. Further, the organization was heavily involved in activities that somewhat paralleled those contemplated in the Act, particularly HCA's multipayer reimbursement pilot, and was reluctant to risk diluting that effort.

From mid- January through February, HCA approached a different statewide organization without success, and approached two large delivery systems about single-entity approaches—again with no positive response. At that point, HCA staff consulted with Senator Pflug, the Act's author. Various combinations of the Act's elements were considered, some of which appeared to fit better with a medical home model like the existing HCA multipayer reimbursement pilot than within an ACO. It was also noted that SB 5394 of 2011, under consideration in the legislature at that time, might offer latitude to incorporate elements of the Act. Further efforts to designate a lead organization or implement the remainder of the Act were discontinued.

Related Activity

Although no further activity has occurred directly pursuant to the Act, there has been substantial activity targeted toward several of its objectives. In particular the Health Care Authority submitted an application September 24, 2012 for the State Innovation Models initiative (SIM) funding opportunity from the Centers for Medicare and Medicaid Innovation (CMMI). The application proposes a virtual, functionally integrated care delivery and payment system that promotes provider accountability by setting provider-specific budgets; provides incentive payment by gain-sharing; shares performance data across providers to reduce variation; and integrates systems by aligning accountability between professional and institutional providers. It will include Medicare, Medicaid and insured as well as self-funded commercial coverage. The primary purpose of the model is health care system transformation to replace volume-based payment with value-based payment, a core objective of ACOs. It is also anticipated that existing and

emerging ACOs will be major participants in the virtual integrated system. In this regard, it is relevant that the Polyclinic in Seattle was the first Washington Medicare ACO designated by the Centers for Medicare and Medicaid Services (CMS).

Further, the proposed model capitalizes on elements from a number of existing public, private and joint initiatives in Washington which address these objectives. Washington is a leader in areas like promotion of evidence-based care, accountability-based incentive payment, use of health information technology, practice transformation, patient/family engagement and collaboration among payers and providers. Specifically, the resources of two existing Washington initiatives—the Dr. Robert Bree Collaborative and the Puget Sound Health Alliance (PSHA)—will be utilized to implement the model. The Bree Collaborative will focus on evidence-based practice to reduce variation and improve quality in perinatal care, and the PSHA “Community Checkup” dataset will support practice transformation in chronic condition management.

The SIM proposal would leverage insight and experience from these public and private initiatives to achieve its purposes. For example, the transition from volume-based to accountability-based payment will be smoothed by the way incentives are structured. Payment will be based on episodes of care so that accountability is shared by facilities and professional providers, but payment is still related to services provided. Similarly, standard quality and utilization performance metrics will enable individual providers to identify best practices and determine the practice transformation methods best suited for them.

Learnings from the ESSB 6522 Experience

The specific provisions of the Act relating to a lead organization and development of an ACO pilot were not realized, but many of its broader objectives are being pursued through other means. While stakeholders were not interested in the lead organization role envisioned by the Act, they are rapidly developing and testing new models. Health care delivery and payment reform in Washington is evolving at an accelerating pace, driven by stakeholder incentives and a steep learning curve about what does and doesn't work. The movement toward greater integration and shared accountability, along with the transition to paying for value rather than volume, continues spontaneously through public initiatives like the SIM and HealthPath Washington proposals, the Department of Health/Washington Academy of Family Practice learning collaborative and HCA's multipayer reimbursement pilot. ESSB 5394 of 2011 also provided strong impetus to accountability-based payment in state purchased health care programs. The public sector is also benefitting from private initiatives like Boeing and Regence's Intensive Outpatient Care Project (IOCP) and Group Health's expansion of its medical home model to its integrated delivery system.

While Washington continues to make progress in payment reform, there remain important opportunities for the public sector to support it further. In particular, antitrust protections can be strengthened for payers and providers who collaborate in multipayer initiatives, as well as greater protections for the deployment of evidence-based care. Importantly, the Bree Collaborative legislation provides such protections through a “safe harbor” from state and federal antitrust laws for activities designed and implemented under the Act. Other examples include promoting development of information-based tools like integrated medical records and multipayer claims databases.

Successful payment reform requires fundamental system changes like transparent pricing and outcomes so we can better connect payment with quality medicine and better outcomes. The SIM proposal would make critical investments in the necessary infrastructure and training to support such endeavors and projects a 5:1 return on that investment over the long term.